PREPARATION AND MAILING INSTRUCTIONS
FORM DPA 2360
HEALTH INSURANCE CLAIM FORM

To facilitate computer processing and to achieve prompt payment for services, high-speed optical character reading equipment is used to process all invoices.

This equipment is designed to read <u>only</u> typewritten or line-printed characters. If the invoice is handwritten (with the exception of the signature), the optical character reader cannot be used, and a manual data input is necessary, which is more time consuming and prone to error. Therefore, it is in the physician's interest to type or line-print all data on the invoice.

The physician should review General Appendix 6 (Technical Guidelines for Preparation of MMIS Invoice Documents for Optical Scanner Processing) at this point.

Please follow these guidelines in the preparation of invoices:

Type of print - use block letters.

C   Use <u>CAPITAL</u> letters only.
C   Leave a space between dollars and cents in all amount fields.
C   Do not use punctuation or special characters anywhere on the form.
C   The instructions identify the fields which are required by the Department. Where indicated, typewritten data must appear for capture by the Optical Character Reader equipment.
C   A <u>Control Number</u>, if used by billing contractors in the preparation of invoices for providers, must be entered in the lower <u>left</u> portion of the invoice in the "Remarks Section". The entry must not extend beyond the center of the page.
C   Type only within the designated spaces provided on the invoice.
C   Use a black (preferably mylar) ribbon only.
C   Strive for accuracy. When correcting an error, use <u>correction fluid</u> only.
C   To ensure that characters are clear and sharp, have your machine serviced and cleaned and the ribbon replaced regularly.
C   All dates should be completed in MMDDYY format. This is a six-digit entry with no dashes, no slashes or spaces, e.g., September 1, 1996 would be entered at 090196.
C   Enter procedure codes as specified in the <u>Current Procedural Terminology</u> (CPT), the appropriate HCPCS codes or any special code, if applicable, as provided in this Handbook or other official notification.
C   All diagnostic coding is to be from "<u>International Classification of Disease, 9th Revision, Clinical Modification</u>" (ICD-9-CM).
C   An original claim must be submitted. Carbon copies and photocopies are not acceptable for processing.

These instructions follow in the order entries appear on the form and address only those fields required by the Department.

Whether or not an entry is always required, conditionally required or optional is indicated as follows:

Required   Entry always required.

Conditionally Required   Entry required based on an entry in another field. Conditions of the requirement are identified in the instruction text.

Optional   Entry not required - in some cases failure to include an entry will result in certain assumptions being made by the Department. These areas are identified in the applicable instruction text.

__COMPLETION STATUS__   __FIELD__

Required   1. __Patient's Name__ - Enter the patient's name exactly as it appears on the MediPlan Card (Form DPA 469) or the Temporary MediPlan Card (Form DPA 1411). An example of a card can be found in Section 131 of Chapter 100.

Conditionally   2. __Patient's Date of Birth__ - An entry is required when charges
Required   are being billed for newborn care or when Form DPA 1411 does not contain a recipient number. Enter the month, day and year of birth of the recipient as shown on the MediPlan Card or the Temporary MediPlan Card. Use the MMDDYY format.

Required   8. __Medicaid Number__ - Enter the nine-digit number assigned to the individual on the MediPlan Card or the Temporary MediPlan Card. Use no punctuation or spaces. __Do not__ use the Case Identification Number.

                                    If the DPA 1411 does not contain the recipient number, attach a copy of this document to the billing form on __first__ submittal. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when Form DPA 1411 is attached.

Conditionally   10. __Condition Related to Employment/Accident Injury__ - If the
Required   patient sought treatment for an injury or illness that resulted from employment, type a capital X in the Yes box under A, Patient's Employment.

COMPLETION STATUS   **FIELD**

If the patient sought treatment for an injury or a condition that resulted from an automobile accident, type a capital X in Field 10B, AUTO.

If the procedure code billed is for Emergency Department Services, then Field 10B, OTHER, must be completed with one of the alphabetic codes shown in Appendix A-12.

Conditionally   19. **Referring Physician Name** - This field is required when
Required   charges are being submitted for a consultation. Additionally, a referring practitioner's name is always required when a referring practitioner number is entered.

Referring Physician Number - The referring practitioner number is always required when a referring practitioner name is entered. Enter the referring practitioner's State license number.

Conditionally   21. **Facility Where Services Rendered** - This entry is required
Required   when the Place of Service Code in Field 24B is other than physician's office or patient's home.

Conditionally   23A **Healthy Kids** - If a provider completed a Healthy Kids
Required   screening or if diagnostic and/or treatment services were rendered as a result of a referral from a Healthy Kids (EPSDT) screening, enter a capital X in the Yes box.

Conditionally   23B **Family Planning** - If services were rendered for family
Required   planning purposes, enter a capital X in the Yes box.

Conditionally   23C **Sterilization/Abortion** - If this invoice is being used to bill for
Required   payment for a Sterilization or Abortion, enter a capital X in the Yes box.

When the service is being submitted for payment for an abortion, a completed copy of Form DPA 2390, Abortion Payment Application must be attached to the invoice and both must be submitted in Form DPA 1414, Special Approval Envelope.

When the service is being submitted for payment for a sterilization, a completed copy of Form DPA 2189, Consent Form, must be attached to the invoice and both must be submitted in Form DPA 1414, Special Approval Envelope.

COMPLETION STATUS   FIELD

When the service is being submitted for payment for a hysterectomy, a completed copy of DPA 1977, Acknowledgment of Receipt of Hysterectomy Information, must be attached to the invoice and both must be submitted in Form DPA 1414, Special Approval Envelope.

All providers involved in the provision of any of these services must attach a copy of the appropriate form to his/her claim.

Required   23E **T.O.S. (TYPE OF SERVICE)** - Enter the code corresponding to the type of service for which the charges submitted on the invoice apply.

Only one type of service can be included on a single invoice. A separate invoice must be prepared for each type of service for which charges are made.

The following Type of Service codes are to be used:

    1 Medical Care - Attending Physician
    2 Surgery - Surgeon
    3 Consultation - Consultant
    4 Diagnostic X-Ray - Radiologist
    5 Diagnostic Laboratory - Pathologist
    7 Anesthesia - Anesthesiologist
    8 Assistance at Surgery - Surgical Assistant
    9 Other Medical Service
    S Co-Surgeon
    Y Second Opinion on Elective Surgery
    G Concurrent Care

Optional   23F **Diagnosis or Nature of Injury or Illness** - Enter the diagnosis or nature of injury or illness description which describes the condition primarily responsible for the patient's treatment. A written description is not required if a valid ICD-9-CM code is entered in Item 24D.

Optional   24. **Repeat Code** - The physician may use the repeat indicator in order to minimize errors and clerical effort required to complete the same data fields in multiple service sections. The date of service must be entered in every service section.

The repeat indicator cannot be used immediately following a service section which has been deleted.

COMPLETION STATUS   **FIELD**

When the repeat box is completed, it must contain a capital "X". Any other character will be ignored. The physician may change any field or fields in the subsequent service section by entering the changed data.

Required   24A   **Date of Service** - Enter the date the service was performed. Use MMDDYY format.

Required   24B   **P.O.S. (PLACE OF SERVICE)** - Enter the numeric or alpha code which identifies the place where the service was provided:

     1 Inpatient Hospital
     2 Outpatient Hospital
     3 Doctor's Office
     4 Patient's Home
     5 Day Care Facility (PSY)
     6 Night Care Facility (PSY)
     7 Nursing Home
     8 Skilled Nursing Facility
     0 Other Locations
     B Other Medical/Surgical Facility
     C Residential Treatment Center
     D Specialized Treatment Center
     E Emergency Department

Required   24C   **Proc. Code/Drug Item No.** - When billing for services, enter the appropriate five-digit procedure code as specified in this Handbook or, if not specified, from CPT-4 or HCPCS.

When billing for dispensed drugs, enter the eight-digit drug item number from the Drug Manual and enter the name and strength of the drug dispensed. The number of tablets/capsules dispensed is to be shown on the service line in the DAYS/ UNITS field (24F).

COMPLETION STATUS   **FIELD**

If an injectable was administered, the appropriate CPT or HCPCS procedure code is to be entered. The drug name, strength, and quantity of the vial dispensed must be shown in the narrative section of the claim.

Conditionally
Required

Modifying Units

1) **Anesthesia**: Enter the appropriate alpha code (see Appendix A-14) to identify the anesthesia modifier units when type of service is code 7, Anesthesia.

2) **Healthy Kids Instructions**: When a procedure code for a Healthy Kids screening referral is used, an entry should be made in the MOD field, on the same line as the screening procedure code.

      J   Referral to self for further medical diagnosis/treatment

      K   Referral to other provider for further diagnosis/treatment

      L   Referral to dentist for evaluation

COMPLETION STATUS   **FIELD**

	M	Referral to self for further medical diagnosis/treatment <u>and</u> dentist for evaluation
	N	Referral to other provider for further diagnosis/treatment <u>and</u> dentist for evaluation

Required   24D   **Primary Diagnosis Code** - Enter the specific ICD-9-CM code for the primary diagnosis described in Item 23F. EXAMPLE: 0303. NOTE: Do not use 9999.

Healthy Kids Instructions: - Enter the specific ICD-9-CM code for the primary diagnosis. The Healthy Kids diagnosis may be:

V202   Routine infant or child health check.

V703   Other medical examination for administrative purposes

       Adoption (DCFS required physical)
       Camp
       School Admission
       Sports Competition

V705   Health examination, preschool (WIC, Headstart/Day School)

       School Children
       Student
       Pre-employment screening

V709   Unspecified general medical examination

Optional   24D   **Secondary Diagnosis Code** - A secondary diagnosis may be entered. Enter only a specific ICD-9-CM code. Do not use 9999.

Required   24E   **Provider Charges** - Enter the total charge, in both dollars and cents, for the service. Do not deduct any Third Party Liability payments from these charges.

Conditionally   24F   **Days/Units** - A four-digit entry is required only for the following:

Required

    C   **Anesthesia Service** (TO=7), enter the duration of time in <u>minutes</u>; e.g., the entry for 1 hour and 10 minutes is 0070.

COMPLETION STATUS   FIELD

C **Drug item dispensed**, enter the number of units dispensed not the unit of measure; e.g., the entry for one unit is 0001.

C Services provided as the **Assistant Surgeon** (TOS=8), enter the duration of time in <u>minutes</u>; e.g., the entry for 1 hour and 10 minutes is 0070.

C When **mileage** is charged (Procedure code W7458), enter the total number of miles one way; e.g., the entry for 32 miles is 0032.

C When billing for **multiples of the same x-ray or laboratory test** where no appropriate bilateral or multiple code exists, indicate the number; e.g., for 3 x-rays or tests, show 0003.

C Allergy testing. Indicate the number of tests, e.g., 0015.

Optional   **Delete** When an error has been made that cannot be corrected, enter a capital "X" to delete the entire service section. Only "X" will be a valid character, all others will be ignored. Use of the Delete does not remove the Primary Diagnosis.

Required   25. **Signature of Physician - and Date Signed** - After reading the certification statement, the physician must sign the completed form. The signature must be handwritten in black or dark blue ink. **A stamped or facsimile signature is not acceptable.** Unsigned claims will not be accepted by the Department and will be returned to the physician when possible. The signature date is to be entered in MMDDYY format. The signature should not enter the date section of this box.

Required   27. **Total Charge** - Enter the sum of all charges submitted on the claim in service sections 1 through 7. Do not include charges from any deleted sections.

Conditionally   28. **Amount Paid** - Enter the sum of all payments received from
Required   other sources. The entry must equal the sum of the amounts as shown in fields 37c and 38c, TPL amount. If no payment was received, enter 0 00.

Required   29. **Balance Due** - Enter the difference between total charges and amount paid fields.

<u>COMPLETION STATUS</u>	<u>FIELD</u>

Required   30. **<u>Your Provider Number</u>** - Enter the Provider Number exactly as it appears on the Provider Information Sheet.

Required   31. **<u>Physician's or Supplier's Name, Address, Zip Code</u>** - Enter the physician's name exactly as it appears on the Provider Information Sheet under "PROVIDER KEY".

Enter the street address of the physician. If an address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If an address is not entered, the Department will not attempt to make corrections.

Enter city, state and zip code of physician or supplier.

Optional   32. **<u>Your Patient's Account Number</u>** - Enter up to 10 numbers or letters used in your accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to you.

Required   33. **<u>Payee Number</u>** - Enter the single digit number of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet.

Required   34. **<u>Number of Sections</u>** - Enter the number of service sections correctly completed above in Section 24. (Do not include **deleted** sections.)

Conditionally Required   37A **<u>TPL Code</u>** - The TPL Code contained on the patient's MediPlan Card (MEC) is to be entered in this field. If payment was received from a third party resource not listed on the MEC, enter the appropriate TPL Code as listed in General Appendix 9. If none of the TPL codes in General Appendix 9 are applicable to the source of payment, enter Code "999" and enter the name of the payment source in Field 9, Other Health Insurance Coverage. If more than one third party made a payment for a particular service, the additional payment(s) are to be shown in Sections 38A-D.

Physicians providing services to women with a diagnosis of pregnancy or preventive services to children are not required to bill a client's private insurance carrier prior to billing the Department for services provided to clients.

COMPLETION STATUS   **FIELD**

SPENDDOWN

If Form DPA 2432, Split Billing Transmittal, shows a recipient liability greater than $0.00 the invoice should be coded as follows:

37A   906
37B   01
37C   the actual recipient liability as shown on form DPA 2432.
37D   the issuance date on the bottom right hand corner of the DPA 2432. This is in MMDDYY format.

If Form DPA 2432, Split Billing Transmittal, shows a recipient liability of $0.00 the invoice should be coded as follows:

37A   906
37B   04
37C   0 00
37D   the issuance date on the bottom right hand corner of the DPA 2432. This is in MMDDYY format.

If the date of service is the same as the "Spenddown Met" date on the DPA 2432, Split Billing Transmittal, attach the DPA 2432 to the claim form.

Conditionally   37B **TPL Status** - A two-digit code indicating the disposition of the
Required   third party billing must be entered. The TPL Status Codes are:

01- TPL Adjudicated - total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient or patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status 02 is to be entered when advised by the third party resource that the patient was not insured at the time goods or services were provided.

03 - TPL Adjudicated - service not covered: TPL Status Code 03 is to be entered when advised by the third party resource that goods or services provided are not covered.

COMPLETION STATUS   **FIELD**

04 - TPL Adjudicated - Spenddown met: TPL Status Code 04 is to be entered when the patient's Form 2432, Split Billing Transmittal, shows $0 liability.

05 - Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered: TPL Status Code 06 is to be entered when the physician determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when an invoice has been submitted to the third party and 30 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met: TPL Status Code 10 is to be entered when the physician has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required   37C **TPL Amount** - Enter the amount of payment received from the third party resource. If there is no TPL amount, enter 0 00. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. If there is a dollar amount entered, also include it in item 28 (Amount Paid).

Conditionally Required   37D **TPL Date** - A TPL date is required when any status code is shown in Item 37B. Use the following dates for the specific TPL status codes:

Code   Date

01   Third Party Adjudication Date or the DPA 2432 Date
02   Third Party Adjudication Date
03   Third Party Adjudication Date
04   Date From DPA 2432
05   Date of Service
06   Date of Service
07   Date of Service
10   Third Party Adjudication Date

COMPLETION STATUS	**FIELD**
Conditionally Required	38A (See 37A above)
Conditionally Required	38B (See 37B above)
Conditionally Required	38C (See 37C above)
Conditionally Required	38D (See 37D above)

MAILING INSTRUCTIONS

The Health Insurance Claim Form is a two-part carbon-interleaf form. The physician is to submit the original portion of the form to the Department as indicated below. The tear strip should be separated from continuous feed forms. The carbon copy of the claim is to be retained by the physician.

Routine invoices are to be mailed to the Department in pre addressed mailing envelopes, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Nonroutine claims are to be mailed to the Department in preaddressed envelopes, Form DPA 1414, Special Approval Envelope, which are provided by the Department for this purpose.

A nonroutine claim is:

1. a claim to which a temporary medical card is attached;

2. a claim to which a document verifying Medicare ineligibility or non-covered Medicare services is attached; or

3. a claim to which X-rays, a consultation report, an operative report, or any other document is attached.